Network Membership Application

All information contained in this application will be considered confidential and only used for the purposes of evaluating applicants for membership in Dentist Direct Dental Plans/Dentist Direct Network Services.

1. Cleary print or type all information.

2. Include additional information where requested in the application. Attach explanations if you answered yes to items in the General Information and Health Status sections requiring additional information.

3. Include your signature and date on the last page.

4. Attach copies of the following documents to this application:

    a. Narcotics registration certificate

    b. Current state license to practice dentistry

    c. Professional liability insurance policy and certificate of coverage from insurance carrier.

    d. Evidence of board status and/or added certificates of accreditation (if applicable).

PLEASE RETURN COMPLETED APPLICATION TO:

Dentist Direct Network Services
75 South 500 West
Bountiful, Utah 84010
(866) 696-6527

Network Membership Application

Category you wish to be listed as in provider directory (Check appropriate box)

☐ General Dentist ☐ Dental Specialist Type_____

Professional category (check appropriate box):

☐ DDS ☐ DMD Other, please specify: _____

Certification and License Information

CPR certified: ☐Yes ☐ No	Date certified	Expiration date	Controlled substance number	Expiration date
State license number	License state	License effective date	License expiration date	

Demographic Information

First Name MI Last Name			Years in Practice	**NPI#**
Social Security Number - -	Federal Tax ID Number	Email Address		

Primary Office	Name	Phone ( ) —	Fax ( ) —
	Address City State Zip		
	*For additional offices use Attachment A		
Residence	Name	Phone ( ) —	
	Address City State Zip		
Billing	Name	Phone ( ) —	
	Address City State Zip		

Practice Information

Office manager (primary contact)	Do you charge an OSHA Fee? ☐ Yes ☐ No	If yes, what is your fee?

Office Schedule	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Practice Arrangements
Starting time								☐ Group
Closing time								☐ Solo

If group practice list the names of dentist belonging to the group

_____ _____

_____ _____

_____ _____

Are you or anyone in your office bilingual?

☐ Yes ☐ No If so, specify language(s):_____

Dental Training

College/University	Degree	Year of graduation
College/University	Degree	Year of graduation

Special courses	Experience deemed relevant by applicant

Specialist Information

Primary	Specialty	
	Certified ☐ Yes ☐ No	Certifying Board
Secondary	Specialty	
	Certified ☐ Yes ☐ No	Certifying Board

General Information

If the answer to any of the following questions is yes, provide a full explanation of details on a separate sheet and attach to this application.

☐Yes ☐ No Have you ever been examined by any specialty board but failed to pass the examination?

☐Yes ☐ No Has your participating provider status in any private, federal or state dental insurance programs been denied, revoked, restricted, subject to disciplinary action or probation or is in the process of being denied, etc?

☐Yes ☐ No Have any academic appointments, institutional affiliations, professional society memberships or board certifications been denied, revoked, restricted, subject to disciplinary action or probation or is in the process of being denied, etc?

☐Yes ☐ No Have you been convicted of a criminal offense other than a minor traffic violation?

☐Yes ☐ No Has your license to prescribe or dispense controlled substances ever been denied, revoked, suspended or restricted?

☐Yes ☐ No Have any disciplinary actions/investigations by any state licensing board been initiated against you?

Professional Liability Insurance

Do you have professional insurance coverage? ☐ Yes ☐ No	Coverage limits: Per occurrence _____ Aggregate _____		
Name of insurer	Policy Number	Length of time with carrier	Expiration date
Coverage Exclusions			

If the answer to any of the following questions is yes, provide a full explanation of details on a separate sheet and attach. Explanations must include company name, date and specific information concerning any limitations, court in which the suit was filed, including case caption or court and docket number, name and address, and phone number of attorney defending you, and any other relevant details.

☐Yes ☐ No Are there any claims currently pending?

☐Yes ☐ No Have any professional liability suits been filed against you within the last five years?

☐Yes ☐ No Have any judgments or settlements been made against you in any professional liability cases within the last five years?

☐Yes ☐ No Has any professional liability insurer ever canceled, declined to cover, or refused to review you on an individual basis for liability coverage?

Health Status

Date of last complete physical exam	Present health status (if fair or poor, please state reason on separate sheet) ☐ Good ☐ Fair ☐ Poor

If the answer to any of the following questions is yes, provide a full explanation of details on a separate sheet attached.

☐Yes ☐ No Do you have any physical or mental problems or chronic illness, which might interfere with your ability to practice?

☐Yes ☐ No Do you have any limitations on your health, live or disability insurance?

☐Yes ☐ No Have you had any problems with alcohol or drug dependency?

Attachment A: Additional office Information

Make copies if additional space is needed

Provider Name: _____ **TIN# _____**

Additional Office

Name	Phone	Fax
	( ) —	( ) —

Address City State Zip

Office manager (primary contact)

Office Schedule	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Starting time							
Closing time							

Practice Arrangements
☐ Group
☐ Solo

If group practice list the names of dentist belonging to the group

_____ _____
_____ _____
_____ _____

Is anyone in this office bilingual?

☐Yes ☐ No If so, specify language(s): _____

TIN# _____

Additional Office

Name	Phone	Fax
	( ) —	( ) —

Address City State Zip

Office manager (primary contact)

Office Schedule	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Starting time							
Closing time							

Practice Arrangements
☐ Group
☐ Solo

If group practice list the names of dentist belonging to the group

_____ _____
_____ _____
_____ _____

Is anyone in this office bilingual?

☐ Yes ☐ No If so, specify language(s): _____

Authorization to Release Confidential Information
To Dentist Direct Network Services

By applying for participation as a provider of dental services under Dentist Direct Network Services, I hereby authorize Dentist Direct Network Services and its authorized representatives to communicate with the following associations/institutions with which I am currently associated (or have been associated in the past) who may have information bearing on my professional competence, character, and ethical qualifications.

- State Dental Association or other dental society.
- State Department of Business Regulation/State Dentist licensing board.
- Professional liability insurance carriers.
- Dental plans in which I am/have been a participating provider (including third party administrators/claims processor).
- Department of Health and Human Services.
- Peer review organizations.

I hereby further consent to the inspection by authorized representatives of Dentist Direct Network Services of all records and reports from associations/institutions as described above that may be material to an evaluation of my professional qualifications, competence, character and ethical qualifications for membership, including evaluations, complaints, claims, disciplinary action and/or recommendations.

I hereby release from liability all authorized representatives of Dentist Direct Network Services for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications.

I hereby release from liability any and all individuals and organizations who provide information to Dentist Direct Network Services and its authorized representatives, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for membership and I hereby consent to release of such information.

I understand and agree that I, as an applicant for membership in Dentist Direct Network Services, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving and doubts about such qualifications, and I understand that any misrepresentations in, or omissions from, this application that bear on my qualifications constitute cause for denial of membership. All information submitted by me in the application is warranted to be true and correct. I further agree to notify Dentist Direct Network Services, of any change in status or other pertinent circumstances that occur during the evaluation of my application.

DATED this _____ day of _____ , 20 _____.

_____ _____

Dentist's Signature Dentist's Name (type/print)

Address City State Zip

Participating Dentist Agreement

Dentist Direct, LLC, is a Utah LLC doing business in Utah as Dentist Direct Dental Plans and Dentist Direct Network Services (the "Corporation"). The Corporation develops, maintains, administers, and at times leases dental care products and dental provider organizations ("Provider Organizations"). Additionally, the corporation has entered, or may enter, into agreements ("Service Contracts") with Dental Insurance companies, Third-party Administrators, and/or Self Funding Groups. These products, services, and Provider Organizations are made available to the Corporation's subscribers and their eligible dependents and at times to other third parties (the "Members"). The undersigned dentist (the "Dentist") is an individual or entity that provides dental care services to the public (the "Services").

Because the Dentist and the Corporation (the "Parties") wish to make the Dentist's Services available to the Members, the Parties agree as follows:

1. The Dentist is an independent contractor and is solely responsible for his own performance and care in the treatment of any Member. Neither of the Parties is an agent, representative, nor employee/employer of the other.

2. The Dentist, as a condition of this Agreement, must at all times hold the appropriate license and credentials to render the Services in the State of Utah. The Dentist will defend, indemnify, and hold the Corporation harmless for any damages that a Member may suffer as a result of the Dentist's conduct.

3. The Dentist will verify, by checking with the Corporation, that the Member is currently eligible to receive the Services and will accept as *payment in full* the applicable amount designated in the Corporation's Fee Schedule(s). Further, the Dentist agrees to apply the appropriate Fee Schedule for the Member's particular plan. The Corporation may update and change the Fee Schedules from time to time. The Dentist agrees that in order to receive payment for any Services rendered, he will comply with all terms and conditions that may be set out in any Service Contracts.

4. The Corporation does not have an obligation or a liability to pay for any of the Services rendered by the Dentist. The Dentist will not, under any circumstances, including the insolvency of: the Corporation; a Third-party administrator; a Self Funding Group; or a Dental Insurance Company, seek payment from the Members for any Services, except for co-payments or discounted pricing as required under the member's applicable plan.

5. The Dentist will submit proper claims information to the designated administrator of any plan on approved forms within ninety (90) days following the date on which the Service was rendered. The Dentist will submit claim forms using the appropriate procedure and diagnostic codes as presented in the most recent additions of the Current Dental Terminology (CDT) as provided by the ADA. The administrator of a plan may deny payment of any claim submitted more than ninety (90) days after the date the Services were rendered. If a claim is denied for untimely filing, and in absence of circumstances sufficiently justifying the untimely filing, the patient may not be billed for the amount of the denied payment.

6. The Dentist will accept new Members and render Services to those Members in the same manner, including the same time availability, as those that the Dentists offer to others. The Dentist agrees that he will only refer Members to other Dentists or Dental Specialists who are part of the Corporation's Provider Organization (except in cases of Emergency or when no Provider Organization Dentist is a available).

7. Upon providing ninety (90) days *written* notice to the Corporation and those existing patients of the Dentist who may be affected, the Dentist may terminate this provider agreement. Thereafter, the dentist will no longer be listed in the Corporation's Provider Directory for that specific plan or plans. Additionally, the parties expressly agree that it is the Dentist's sole responsibility to notify and/or decline service to existing patients or Members who may wish to become patients, on that specific plan or plans which the Dentist has canceled.

8. The Dentist agrees to maintain policies of malpractice and other insurance, as necessary, to insure that the Dentist and his employees are covered against any claims for damages. The amounts and extent of the insurance coverage shall not be less than $100,000 per occurrence and $300,000 in the aggregate. Further, the Dentist agrees to provide the Corporation or other designate, with certificates, or proof of insurance, and immediate notice of any change thereof.

9. The Dentist will keep dental, administrative and financial records, and upon request, will furnish them to the Corporation or a designated representative of a Dental Insurance Company, a Self Funding Group, or Third-party Administrator. The Dentist will make these records available for inspection, in his office during normal business hours, provided however, that the Dentist shall have no obligation to disclose confidential information without proper authorization from the member.

10. This agreement shall be effective as of the date of execution and will remain in effect for a period of one (1) year. Thereafter, this Agreement will automatically renew for successive one (1) year periods. This Agreement may be terminated at any time with or without cause by either party by written notice given at least five (5) days (with cause) at ninety (90) days (without cause). Upon termination, the rights of the Parties will extinguish except that any termination will not release the Dentist from providing written notice to those patients who may be affected by his contract termination and from his obligation to complete treatment of the Members then receiving care. It is the dentist's responsibility to notify potentially affected new Members and existing patients of their change in contract status.

11. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as a waiver of any subsequent breach and the invalidity of any terms or conditions shall in no way affect the validity or enforceability of any other term or provision. In the event of any inconsistency between this Agreement and any Service Contract, the Parties agree that the Service Contract shall control.

12. This Agreement shall be governed in all respects by the laws of the State of Utah and any applicable federal statues and regulations. Any fees, including attorney's fees, associated with enforcing the provisions of this agreement shall be paid by the losing party opposing such enforcement.

13. The Dentist shall not assign or otherwise transfer rights, nor delegate duties under this Agreement to any other party without the prior written consent of the Corporation.

14. Any notices required to be given pursuant to the terms and provisions of this Agreement shall be sent by certified mail, return receipt requested, postage paid, addressed to each party at its current address. Each party shall give written notice to the other in the event of any changes of address to which notices required by this agreement should be sent.

15. I agree to provide my services for all offered plans by the Corporation for the contracted fees set forth in the schedule of procedure fees. **I understand that I will receive the exact same total fee for each covered procedure, regardless of which plan the patient uses.**

Please Initial _____

For the purposes of this Agreement, I, the undersigned, agree to participate as a (check one box):

_____ **DENTIST (as defined herein)**

_____ **DENTAL SPECIALIST (as defined herein)**

IN WITNESS WHEREOF, the undersigned have executed this Agreement this ____ day of _____ 20____.

_____
Dentist's Name

_____
Dentist's Signature

_____ _____
Social Security Number **Tax ID Number**

Dentist Direct Dental Network Services
75 South 500 West
Bountiful, Utah 84010
866-696-6527

Authorized Representative

NON-DISCLOSURE/CONFIDENTIALITY AGREEMENT

This Agreement will establish the basis upon which **Dentist Direct,** LLC, and its affiliated companies having a principal place of business at 75 South 500 West, Bountiful, Utah 84010 and its employees or agents, (hereinafter "Discloser") and **Dr. _____, a licensed dental provider**, (hereinafter "Receiver") have or will exchange information (hereinafter referred to as the "Confidential Information"), which is any information given by the Discloser to the Receiver and may include but is not limited to data, formulae, methods, processes, specifications, writings, illustrations, photographs, or other information which the Discloser deems proprietary and confidential. (From time to time the parties hereto may jointly be referred to as "Parties" or individually as a "Party") (hereinafter, "Agreement").

NOW, THEREFORE, in consideration of the mutual promises set forth herein, and other good and valuable consideration, the receipt and sufficiency of which is expressly acknowledged hereby, the Receiver hereby agrees to be bound as follows:

Disclosure of Confidential Information. During the term of this Agreement and for 1 year thereafter, the Receiver shall keep confidential and not make external use of any proprietary business information, fee schedules, and related data. This includes discussing or sharing orally or in writing any specific or general fee information with other dental providers and/or their employees, agents, consultants, family members, or staff. Receiver will not disclose any fee information without the express written consent of Discloser.

Remedies for Breach. If it is discovered that the Receiver share this information, the provider's contracted fees shall immediately revert to the lowest available schedule and/or the provider agreement may be terminated for cause at the discretion of the Discloser.

It is understood and agreed that this agreement is binding upon each party's employees, agents, affiliates, and assigns, without limitation.

IN WITNESS WHEREOF, Receiver represents and warrants that the individual executing this Agreement below is the Receiver as of the date hereof.

DATED this _____ day of _____, 20__.

By: Receiver

Signature:

_____